

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO**

ANGELICA POLANCO,

Plaintiff,

vs.

PRUCO LIFE INSURANCE COMPANY, a
corporation; WILLIAM A. FORTNER;
HEATHER FORTNER; and MOUNTAIN WEST
INSURANCE & FINANCIAL SERVICES, LLC,
a limited liability company.

Defendants.

CASE NO. 1:22-cv-00765-KWR-JFR

**DECLARATION OF SEAN
O'BRIEN I/S/O DEFENDANT
PRUCO'S OPPOSITION TO
PLAINTIFF'S MOTION TO
REMAND**

**DECLARATION OF SEAN O'BRIEN IN SUPPORT OF PRUCO LIFE INSURANCE
COMPANY'S OPPOSITION TO PLAINTIFF'S MOTION TO REMAND**

I, Sean O'Brien, declare as follows:

1. I hold the position of Operations Manager at Pruco Life Insurance Company ("Pruco"). As the Operations Manager, I help manage the day-to-day activities of Pruco's individual life insurance beneficiary services department. I am personally familiar with the document retention and storage regarding Pruco customer's transactions, products, claims, and files, and have personal knowledge of the documents maintained in Pruco's policy records for Bernardo Polanco, which are stored and maintained by Pruco in the ordinary course of business as business records. I am competent to testify to the matters set forth in this declaration, and if called upon to do so, I could and would so testify.

2. Attached as **Exhibit A** is a true and correct copy of selected portions of the August 19, 2014 \$1,000,000 term life insurance policy (policy no. L9105866; the “5866 Policy”) from Pruco insuring the life of Bernardo Polanco, and listing Mr. Polanco as the owner and Angelica Polanco as beneficiary, maintained in Pruco’s policy records.

3. Attached as **Exhibit B** is a true and correct copy of the September 15, 2017, “Customer Request to Change Address” changing Mr. Polanco’s address of record to PO Box 2667, Farmington, NM, maintained in Pruco’s policy records. Mr. Polanco did not subsequently change his address of record.

4. Attached as **Exhibit C** is a true and correct copy of the September 28, 2021 letter providing notice of lapse sent by Pruco to Bernardo Polanco’s address of record, maintained in Pruco’s policy records. The letter advised, *inter alia*, that that Mr. Polanco could reinstate the Policy No. L9102961 (the “2961 Policy”) by promptly paying the past due premium of \$4,625.00 by October 20, 2021. No such premium payment was received by Pruco by October 20, 2021.

5. Attached as **Exhibit D** is a true and correct copy of the October 21, 2021 letter providing notice of lapse sent by Pruco to Bernardo Polanco’s address of record, maintained in Pruco’s policy records. Mr. Polanco did not apply for reinstatement at this time, nor did Pruco receive a premium payment sent at this time.

6. Attached as **Exhibit E** is a true and correct copy of the January 4, 2022 letter regarding application for reinstatement sent by Pruco to Bernardo Polanco’s address of record, maintained in Pruco’s policy records.

7. Attached as **Exhibit F** is a true and correct copy of selected portions of the January 15, 2022 Application for Reinstatement, maintained in Pruco's policy records.

8. Attached as **Exhibit G** is a true and correct copy of the January 25, 2022 letter regarding receipt of reinstatement application sent by Pruco to Bernardo Polanco's address of record, maintained in Pruco's policy records.

9. Attached as **Exhibit H** is a true and correct copy of the February 18, 2022 letter regarding withdrawal of reinstatement of policy sent by Pruco to Bernardo Polanco's address of record, maintained in Pruco's policy records.

10. Attached as **Exhibit I** is a true and correct copy of selected portions of the Life Underwriting Guide Memo re: Change and Reinstatement Underwriting, maintained in Pruco's records.

11. Attached as **Exhibit J** is a true and correct copy of selected portions of the Producer Life Underwriting Service (PLUS) Underwriter Workbench for Policy no. L9102961, maintained in Pruco's policy records.

12. Attached as **Exhibit K** is a true and correct copy of the check sent by Prudential to Angelica Polanco for her portion of the death benefit on the 5866 Policy, maintained in Pruco's policy records.

13. Attached as **Exhibit L** is a true and correct copy of the April 5, 2022 letter regarding approval for the claim of benefits on the 5866 Policy sent by Pruco to Angelica, maintained in Pruco's policy records.

14. Attached as **Exhibit M** is a true and correct copy of selected portions of Bernardo Polanco's Application for Life Insurance for the 5866 Policy, maintained in Pruco's policy records.

15. Attached as **Exhibit N** is a true and correct copy of selected portions of Bernardo Polanco's Application for Life Insurance for the 2961 Policy, maintained in Pruco's policy records.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed on November 15th, 2022, in Jacksonville, FL.

Sean O'Brien

SEAN O'BRIEN

CERTIFICATE OF SERVICE

I, hereby certify that on November 16, 2022, I electronically filed the **DECLARATION OF SEAN O'BRIEN IN SUPPORT OF PRUCO LIFE INSURANCE COMPANY'S OPPOSITION TO PLAINTIFF'S MOTION TO REMAND** with the Clerk of Court using the CM/ECF system, which caused a copy of the **DECLARATION OF SEAN O'BRIEN IN SUPPORT OF PRUCO LIFE INSURANCE COMPANY'S OPPOSITION TO PLAINTIFF'S MOTION TO REMAND** to be sent to the following:

ATKINSON, BAKER & RODRIGUEZ, P.C.
Clifford K. Atkinson
Justin D. Rodriguez
Julia E. McFall
201 Third Street NW, Suite 1850
Albuquerque, NM 87102
(505) 764-8111
catkinson@abrfirm.com
jrodriguez@abrfirm.com
jmcfall@abrfirm.com

Attorneys for Plaintiff Angelica Polanco

Henry Narvaez
Narvaez Law Firm, P.A.
601 Rio Grande Blvd NW
Albuquerque, New Mexico 87104
hnarvaez@narvaezlawfirm.com
Attorneys for Agency Defendants

MODRALL SPERLING ROEHL HARRIS & SISK, P.A.

By: /s/ Kevin D. Pierce
Kevin D. Pierce

EXHIBIT A

Pruco Life Insurance Company
213 Washington Street, Newark, NJ 07102-2992
A Stock Company Subsidiary of
The Prudential Insurance Company of America

Insured BERNARDO POLANCO

L9 105 866 **Policy Number**
AUG 19, 2014 **Contract Date**

Agency KABX

Term Life Policy. Provides a level benefit. Life insurance payable upon death within stated term period. Premiums payable during Insured's lifetime for stated premium period. After a period of level premiums, the premiums will increase annually as shown under Premium Period on page 3. Premiums are subject to change on a class basis on and after the Guaranteed Premium End Date shown on page 3. Convertible, as limited, but not renewable. Non-participating.

We will pay the beneficiary the death benefit described in this contract promptly if we receive due proof that the Insured died in the term period. We make this promise subject to all the provisions of this contract. The term period starts on the contract date. The anniversary at the end of the term period is part of the term period.

If there is ever a question about this contract, just see a Pruco Life representative or contact one of our offices.

10-Day Right to Cancel Contract. -If you return this contract to us no later than 10 days after you receive it, we will refund your money promptly. The contract will be canceled from the start. (If the purchase of this contract is a replacement under state law, this duration will be extended to the period required by such law, but not to exceed 30 days.) All you have to do is take it or mail it to one of our offices or to the representative who sold it to you.

Signed for Pruco Life Insurance Company,
an Arizona Corporation.

 **SPECIMEN**

Secretary

 **SPECIMEN**

President

PLEASE READ YOUR POLICY CAREFULLY; it is a legal contract between you and Pruco Life.

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A copy of the application and any riders or endorsements can be found at the end of the contract.

SPECIMEN

CONTRACT DATA

Insured

BERNARDO POLANCO Male, Issue Age 47

Rating Class

Nonsmoker D

Basic Contract Information

Policy Number L9 105 866
Contract Date August 19, 2014
Term Period 48 years
Premium Period 48 years
Guaranteed Premium
End Date August 19, 2024
Beneficiary ANGELICA POLANCO, spouse

Life Insurance on the Insured

Basic Amount \$1,000,000.00

Schedule of Premiums

Scheduled Premiums are guaranteed until the Guaranteed Premium End Date. On and after the Guaranteed Premium End Date, Scheduled Premiums may be increased or decreased but will not exceed the Maximum Premiums shown for that year. (See Changes in Premium Rates.)

Total Initial Premium on Contract Date for the following modes:

Annual	Semi-annual	Quarterly	Monthly
\$4,625.00	\$2,405.00	\$1,225.63	\$416.25

Contract premiums are due on the contract date and every 1 month after that date. The monthly premium is \$416.25 and changes as shown below.

Premium Change Date(s)	Scheduled Premiums	Maximum Premiums
AUG 19, 2024	\$3,624.75	\$3,897.45
AUG 19, 2025	\$3,948.75	\$4,248.45
AUG 19, 2026	\$4,330.35	\$4,656.15
AUG 19, 2027	\$4,792.05	\$5,154.75

CONTRACT DATA CONTINUED ON NEXT PAGE

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EXHIBIT B

**Prudential**

The Prudential Insurance Company of America
Prudential Retirement
P.O. Box 70197
Philadelphia, PA 19178

Customer request to change address

For use by structured settlement annuitants/payees only

Please print using blue or black ink

Information

The customer identified in section 1 below (Customer) is named as an annuitant/payee under a structured settlement annuity contract (the SSA Contract) issued by Prudential. The SSA Contract is owned by a financial institution or government entity (the Owner). The Customer is requesting a change in address on Prudential's records for notices and/or payments, as indicated below. If amounts due under the SSA Contract are payable jointly to two or more annuitants/payees, all such annuitants/payees must sign this form to authorize any change in address for payments.

1 Customer information

<u>Bernardo</u>		<u>Polanco</u>
First name of customer	Middle initial	Last name
<u>L9 102 961</u>		<u>[REDACTED]</u>
Contract number		Social Security number
<u>(505) 486-1717</u>		
Telephone number		

2 Electronic Funds Transfer (EFT) information

Are your structured settlement payments currently deposited to a bank account by EFT? ☐ Yes ☐ No

- a. If **No**, and you wish to enroll for automatic deposit of structured settlement payments to a bank account (account must be in your name), use the Electronic Funds Transfer Enrollment form. If you also need to change address for notices, go to section 3 below and continue to complete this form.
- b. If **No**, and you do not wish to enroll in EFT deposit, go to section 3 below and continue to complete this form to change address for notices and payments.
- c. If **Yes**, do you wish to continue to use EFT to receive payments? ☒ Yes ☐ No
- If **Yes**, go to section 3 below and continue to complete this form to change address for notices. (If you need to change your EFT bank account information, please send notice of your changes to the address below.)
 - If **No**, and you wish to cancel EFT deposit arrangements and have notices and payments mailed to the same address, confirm by selecting the box below.
- ☐ The undersigned annuitant/payee and joint annuitant/payee, if any, hereby authorize(s) Prudential to cancel existing EFT deposit arrangements and mail notices and payments to the same address, as indicated below
- To have notices and payments mailed to your current address on Prudential's records, complete section 3a.
- To have notices and payments mailed to a new address, complete sections 3a and 3b.

3 Customer's address

a. Please tell us your current address This current address is for: ☒ Notices ☒ Payments

<u>1560 Saguaro Trail</u>		
Street	Apt	
<u>Farmington</u>	<u>NM</u>	<u>87401</u>
City	State	ZIP code

09242017 12:58 SCANNER14 1 04751

0927201708:455 SCANNER11 1 0258

3 Customer's address (continued)b. Please tell us your new address This new address is for: ☒ Notices ☒ Payments*

*If amounts due under the SSA Contract are payable jointly to two or more annuitants/payees, all such annuitants/payees must sign this form to authorize any change in address for payments.

PO Box 2667
 Street
 FARMINGTON
 City
 Apt
 NM
 State
 87499
 ZIP code

4 Effective date(s) (optional)

You may tell us the date your requested change in address should start. The starting date can be the same as an annuity payment date. You may also tell us when any requested change should expire. Details of your address after the expiration date must be provided on a separate address change form. To make any change effective on a specific date, however, we need to receive the appropriate form at least 30 calendar days prior to such date.

Starting date:

month day year

Expiration date:

month day year

5 Signature

The undersigned agree(s) that any change requested on this form and accepted by Prudential will remain effective until and unless the undersigned submits to Prudential in writing and Prudential accepts any subsequent request to change address, or any law or legal notice binding on Prudential requires otherwise. The effective date of an address change will not be more than 30 calendar days after receipt of this form, duly completed, at the address set forth below. No change of address shall be accepted and made effective, however, if in good faith Prudential determines that such change is, or may be, in conflict with any applicable law, court order or the claims of any other person.

X Brenda Rodriguez
 Signature of annuitant/payee or annuitant/payee's guardian¹

Name of annuitant/payee or annuitant/payee's guardian

X
 Signature of joint annuitant/payee or joint annuitant/payee's guardian^{1,2}

Name of joint annuitant/payee or joint annuitant/payee's guardian

09 15 2017
 month day year

¹ If any annuitant or joint annuitant is a minor or lacks legal capacity, this form must be signed by the legal guardian responsible for the custody and care of such annuitant's financial interests with respect to the SSA Contract identified herein.

² If amounts due under the SSA Contract identified herein are payable jointly to two or more annuitants/payees, all such annuitants/payees must sign this form.

6 Mailing instructions

Please return this form completed and signed to:

The Prudential Insurance Company of America
 Prudential Retirement
 P.O. Box 70197
 Philadelphia, PA 19176

To be completed by Prudential Structured Settlement Staff:

Contract Owner _____

EXHIBIT C



PO Box 41594
Philadelphia, PA 19176
Phone: (800) 782-5356
TTY: (800) 778-8633

Have Questions?

Visit www.prudential.com

Or call your financial professional:

William A Fortner
(505) 327-4441

September 28, 2021

BERNARDO POLANCO
PO BOX 2667
FARMINGTON NM 87499-2667

Owner: Bernardo Polanco
Insured: Bernardo Polanco
Policy Number: L9 102 961

Dear Bernardo Polanco:

We have not received your annual premium payment that was due on August 19, 2021. As a result, the life insurance policy listed above lapsed on September 19, 2021, and no longer provides coverage. However, you can still reinstate your policy without having to answer any health questions.

To reinstate your policy, just mail the attached payment coupon and your payment made payable to Prudential for \$ 4,625.00. This represents the past-due payment for August. Please mail your payment so that we receive it by October 20, 2021. Carefully review the "Information Regarding Reinstatement" included with this letter for additional details.

If you want to make your reinstatement payment online from your checking or savings account, go to www.prudential.com/login. After logging in, select Make A Payment. Not yet registered on our website? Go to www.prudential.com/login and select Register Now. You can also pay by phone by calling us at the number above. Please note that online payments must be submitted no later than 4:00 p.m., Eastern time, on the due date. If the due date falls on a weekend or holiday, the payment must be submitted no later than 4:00 p.m., Eastern time, on the business day before the due date.

You may disregard this letter if you've already sent your payment.

Simplify Your Future Payments Through Electronic Funds Transfer (EFT).

With the Electronic Funds Transfer (EFT) payment program, you can have your premiums automatically withdrawn from your checking or savings account each month. This saves time and postage and helps ensure your policy won't lapse because you forgot to mail your payment.

To be eligible for EFT, your policy must first be reinstated. Then, simply contact us at the number shown above. Please note that switching to a payment frequency other than annual, including paying monthly through EFT, may result in a higher total premium amount for the year.

We value your business and look forward to hearing from you soon.

Sincerely,

Kimberly King

Kimberly King
Vice President, Operations

Enclosure



Information Regarding Reinstatement

Although this policy lapsed at the expiration of its grace period, you can reinstate coverage without evidence of insurability, subject to the following:

- **Payment must be received by Prudential before the death of the insured.**
- The amount needed to reinstate your policy may change if your payment is not received on or before October 20, 2021.
- The form of your payment must be honored.
- Additional requirements may apply when reinstating more than one policy covering the same insured. If additional requirements do apply, we will notify you in writing.

The information above applies only to reinstatement of the policy referenced in this notice and not to any other policy or any later attempt to reinstate the above referenced policy. The above items limit your ability to reinstate this policy without answering questions about the insured's health. We are not waiving our contractual right to require proof of insurability.

This document, and the information contained within, is not intended as investment advice and is not a recommendation about managing or investing your retirement savings. Neither The Prudential Insurance Company of America, Pruco Life Insurance Company, Pruco Life Insurance Company of New Jersey, nor any other Prudential entity is acting as your fiduciary as defined by any applicable laws and regulations by delivery of this document. Please consult with your qualified investment professional about managing or investing your retirement savings.

Life insurance is issued by The Prudential Insurance Company of America, Pruco Life Insurance Company (except in NY and/or NJ), or Pruco Life Insurance Company of New Jersey (in NY and/or NJ). All are Prudential Financial Companies.

Please mail your payment together with the coupon below in the envelope provided.

Remember: Additional requirements may apply when reinstating more than one policy covering the same insured.

Payment Coupon

LP77700 AB KABXM S88GNT

Page 3 of 4

See payment instructions below.



Prudential

Owner: Bernardo Polanco

Insured: Bernardo Polanco

Policy Number: L9 102 961

Notice Date: September 28, 2021

- Please make your check payable to **Prudential** and write your policy number on the check.
- Please detach and return this coupon with your check in the enclosed envelope. **Our Payment Return Address** on the back of this coupon should appear in the envelope window.

Due Date	October 20, 2021
Payment Due	\$ 4,625.00
Total Amount Enclosed	\$

XL91029613004625000000000000000000999999000B4KABXYO

PRU_0000311

EXHIBIT D



PO Box 41594
Philadelphia, PA 19176
Phone: (800) 782-5356
TTY: (800) 778-8633

Have Questions?

Visit www.prudential.com

Or call your financial professional:

William A Fortner
(505) 327-4441

October 21, 2021

BERNARDO POLANCO
PO BOX 2667
FARMINGTON NM 87499-2667

Owner: Bernardo Polanco
Insured: Bernardo Polanco
Policy Number: L9 102 961

Notice of Lapse

Dear Bernardo Polanco:

I am writing to inform you that your term life insurance policy has lapsed because we have not received the premium due on August 19, 2021.

We are pleased to tell you that you can apply to reinstate your policy so that its insurance protection can be continued.

To Apply for Reinstatement

To apply for reinstatement, call your financial professional or the number listed above for an application and a quote of the amount you will need to submit.

We value your business and look forward to hearing from you soon.

Sincerely,

Kimberly King

Kimberly King
Vice President, Operations

Life insurance is issued by The Prudential Insurance Company of America, Pruco Life Insurance Company (except in NY and/or NJ), or Pruco Life Insurance Company of New Jersey (in NY and/or NJ). All are Prudential Financial Companies.

EXHIBIT E



Prudential

Customer Service Office
P.O. Box 7390
Philadelphia, PA 19176-7390
www.prudential.com

Bernardo Polanco
Po Box 2667
Farmington, NM 87499-2667

Insured: Bernardo Polanco
Policy Number: L9102961

January 4, 2022

Dear Bernardo Polanco:

I am writing in response to the request you made to reinstate insurance coverage under the policy listed above.

The premiums are paid to August 19, 2021. Please note that you have no insurance coverage under this policy, except to the extent of the non-forfeiture provision (if any) specified in the policy. To apply for reinstatement, please send us a payment of \$4,625.00 by January 25, 2022, along with the completed and signed Application for Reinstatement. If the payment and application for reinstatement is received after January 25, 2022, the amount required to reinstate may change. It is important that all payments and forms be mailed together to avoid delays. If your application is approved, the policy will be reinstated.

Enclosed you will find an application for reinstatement. Please complete the entire application and return it to us with your payment. **If every question is not answered in full, we will be required to reject your request for reinstatement and you will need to complete and submit a new application and an additional payment may be required.**

In order for us to consider your application, the following is required:

- Bernardo Polanco must answer all questions and initial any changes or corrections.
- A full explanation of any "yes" answer in Part 1, section D (General Information), must be provided where indicated at the end of the section.
- A full explanation of any "yes" answer in Part 2, section D (Medical Information), must be provided where indicated at the end of the section.
- Bernardo Polanco must sign and currently date the application.
- Bernardo Polanco must sign and currently date the Authorization to Release Information.

In addition, you must also return:

- The full amount needed to reinstate.

In order to determine if this policy can be reinstated, we may require that Bernardo Polanco take a medical examination. If an examination is required you will be contacted by a company working on behalf of Prudential to schedule the examination as part of the evaluation process. Please read the enclosed Important Notice About Your Application for Reinstatement carefully and retain it for your records, as it provides information regarding the medical examination process if one is required.

If you have any questions or would like more information, please call our customer service office at (800) 782-5356 and refer to reference number AMRWZC8F. We are available Monday through Friday between 8:00 a.m. and 7:00 p.m. Eastern time. If you are using a telecommunications device for the hearing impaired, please call (800) 778-8633, Monday through Friday between 8:00 a.m. and 6:00 p.m. Eastern time. One of our customer service representatives will be glad to help you.

Thank you for choosing us for your insurance and financial needs.

Sincerely,

Alexis Shaw

Alexis Shaw
Associate Manager

Enclosures

This document, and the information contained within, is not intended as investment advice and is not a recommendation about managing or investing your retirement savings. Neither The Prudential Insurance Company of America, Pruco Life Insurance Company, Pruco Life Insurance Company of New Jersey, nor any other Prudential entity is acting as your fiduciary as defined by any applicable laws and regulations by delivery of this document. Please consult with your qualified investment professional about managing or investing your retirement savings.

EXHIBIT F

**Prudential****APPLICATION FOR REINSTATEMENT****PART 1**

- ☒ The Prudential Insurance Company of America
☒ Pruco Life Insurance Company
Both are Prudential Financial companies.
 Corporate Offices, Newark, New Jersey

PLEASE PRINT USING BLUE OR BLACK INK.

A. POLICY INFORMATION (TO BE COMPLETED BY POLICYOWNER.)

Policy number(s)

L9102961

Policyowner's current mailing address (Street, Apt., City, State, ZIP)

PO Box 2667 Farmington, NM 87499Type of owner: ☒ Individual ☐ Multiple ☐ Business ☐ TrustName of policyowner (First/M/Last) Enter "same" if same as insured.
same

Policyowner's telephone numbers:

Daytime 505-486-1010 Evening 5054861717

Name of joint owner, if any (First/M/Last)

Is the policyowner considering the transfer or sale to a life settlement company or other investor of: policy ownership;
 or, any interest in the policy benefits, either directly as a named beneficiary or indirectly as a beneficiary or owner of
 a trust or other entity?

☐ Yes ☒ No*If Yes, provide details:***B. PRIMARY INSURED'S INFORMATION (TO BE COMPLETED BY PRIMARY INSURED.)**1. Name of primary insured (First/M/Last) Bernardo Polanco2. Current employer name Lobo Well Service Telephone number 505-564-30003. Business address: Street 5630 Bloomfield Hwy. Suite _____
City Farmington State NM ZIP 874994. Occupation Oilfield Supervisor Duties Field Supervisor

5. If the primary insured or any covered person has changed his or her last name in the last five years, give:

Current name _____ Previous name _____

This will not change the name on the policy. If you want to change the name, please contact our Customer Service Office.

6. Are you applying for or reinstating life insurance with any company? ☐ Yes ☒ No*If Yes, give company name, amount applied for and/or reinstating, including this application:*7. Has any person for whom you are applying for coverage to be reinstated had life or health insurance declined,
postponed, rated or issued with an increased premium? ☐ Yes ☒ No*If Yes, give company name, type of insurance, date, action taken and reason for action:*

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1



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PRU_0000274

04/21/2207.5369.000.142

C. OTHER INSURED (TO BE COMPLETED BY POLICYOWNER.)

Use this section to provide information on the primary insured's spouse and children. The following information must be provided for each person for whom you are applying for coverage to be reinstated.

- | 1. Name (First/MI/Last) | Age | Date of birth | Place of birth | Relationship to Primary Insured | Sex |
|-------------------------|-----|---------------|----------------|---------------------------------|--|
| Angelica Polanco | 55 | | Mexico | Spouse | <input type="checkbox"/> M <input checked="" type="checkbox"/> F |
| | | | | | <input type="checkbox"/> M <input type="checkbox"/> F |
| | | | | | <input type="checkbox"/> M <input type="checkbox"/> F |
| | | | | | <input type="checkbox"/> M <input type="checkbox"/> F |
| | | | | | <input type="checkbox"/> M <input type="checkbox"/> F |
2. Has any covered family member died since the first missed premium due date or the date of the default? ☐ Yes ☒ No
If Yes, please give the person's name and date of the death below.
 Name _____ Date (MM/DD/YYYY) _____
3. Are any children named above:
 a. foster children or children whose legal adoption has not been made final? ☐ Yes ☒ No
 b. not living in the primary insured's household? ☐ Yes ☒ No
 c. dependent on someone other than the primary insured? ☐ Yes ☒ No
4. If Applicant's Waiver of Premium (AWP) benefit is to be reinstated, please list the name of the applicant under AWP.
Bernardo Polanco

D. GENERAL INFORMATION (TO BE COMPLETED BY PRIMARY INSURED.)

1. In the past five years, has any person for whom you are applying for coverage to be reinstated flown as a pilot, student pilot or crew member or do they intend to become a pilot? ☐ Yes ☒ No
2. In the past five years, has any person for whom you are applying for coverage to be reinstated participated in any activities such as motorized vehicle racing, SCUBA diving, mountain climbing, skydiving, extreme sports such as BASE jumping, bungee jumping or cave exploration, or do they intend to? ☐ Yes ☒ No
3. Has either the primary insured or covered spouse (if any) ever used tobacco or any other nicotine products such as cigarettes, cigars, pipe, chewing tobacco, snuff, nicotine gum or nicotine patch? ☐ Yes ☒ No
If Yes, provide details:
- | | Product Type(s) | Date Last Used | Frequency of Use |
|-----------------|-----------------|----------------|------------------|
| Primary insured | _____ | _____ | _____ |
| Covered spouse | _____ | _____ | _____ |
4. In the past five years, has any person for whom you are applying for coverage to be reinstated:
 a. had a driver's license denied, suspended or revoked? ☐ Yes ☒ No
 b. been convicted of or pled guilty to driving under the influence of alcohol and/or drugs? ☐ Yes ☒ No
 c. been convicted of or pled guilty to any moving violations? ☐ Yes ☒ No
5. Within the past 10 years, has any person for whom you are applying for coverage to be reinstated been arrested, convicted, or imprisoned for any crime and/or is currently awaiting trial for any crime? ☐ Yes ☒ No
6. Will any person for whom you are applying for coverage to be reinstated live or travel outside the United States within the next 12 months? ☐ Yes ☒ No
Details required include location (city/country), frequency, duration and purpose of each trip.

(CONTINUED)

COMB 6641 2010 NEW MEXICO

Return this page to Prudential

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CASAMRWZC8F-01



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01/21/2027.5369.000.143

D. GENERAL INFORMATION (TO BE COMPLETED BY PRIMARY INSURED.) CONTINUED

7. Give complete details of any "Yes" answers for questions 1, 2, 4 – 6, including question number, name and appropriate details:

Question # Name of Person Details

PART 2 (THIS INFORMATION MUST BE PROVIDED FOR EACH PERSON FOR WHOM YOU ARE APPLYING FOR COVERAGE TO BE REINSTATED.)**A. PERSONAL PHYSICIAN INFORMATION (TO BE COMPLETED BY PRIMARY INSURED.)****PRIMARY INSURED**Name Joseph Pope, MDAddress: Street 2300 E 30th St. Suite C2City Farmington State NM ZIP 87401Telephone number: (505) 324-1000 Date last seen: December 30Reason last seen: General checkup*If more than one personal physician, please provide details in section D, number 6.***COVERED SPOUSE OR APPLICANT FOR APPLICANT'S WAIVER OF PREMIUM**Name Joseph Pope, MDAddress: Street 2300 E 30th St. Suite City Farmington State NM ZIP 87401Telephone number: (505) 324-1000 Date last seen: December 30Reason last seen: General checkup*If more than one personal physician, please provide details in section D, number 6.***B. PHYSICAL MEASUREMENTS (TO BE COMPLETED BY PRIMARY INSURED.)**1a. Height: 5 feet 6 inches Weight: 190 pounds (Primary Insured)b. Height: 5 feet 1 inches Weight: 135 pounds (Covered Spouse or Applicant for Applicant's Waiver of Premium)

2. Within the last 12 months, has any person for whom you are applying for coverage to be reinstated had a change of weight (gain or loss) of more than 10 pounds?

☐ Yes ☒ No*If Yes, provide details:*

(CONTINUED)

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C. FAMILY HISTORY (TO BE COMPLETED BY PRIMARY INSURED.)

1. Have any immediate family members (mother, father, brother, sister) been diagnosed with or died from coronary artery disease, cerebrovascular disease, diabetes or cancer before age 70? ☐ Yes ☒ No

If Yes, provide details including which member and medical condition, age at diagnosis, and age at death (if applicable):

Mother died of Ovarian Cancer

2. Father: Current age _____ or Age at death 74 Mother: Current age _____ or Age at death 48

D. MEDICAL INFORMATION (TO BE COMPLETED BY PRIMARY INSURED.)

1. Has any person for whom you are applying for coverage to be reinstated ever been treated by a member of the medical profession for, or been diagnosed with:
- a. high blood pressure, chest pain, a heart attack, coronary artery disease, a heart valve disorder, a heart murmur, an irregular heart beat, cerebrovascular disease, a stroke, circulatory disease, an aneurysm or any disease of the heart or blood vessels? ☐ Yes ☒ No
 - b. anemia or other abnormality of the blood (other than HIV)? ☐ Yes ☒ No
 - c. a polyp, cyst, tumor, cancer, leukemia, melanoma, lymphoma or Hodgkin's disease? ☐ Yes ☒ No
 - d. diabetes, high blood sugar, glucose intolerance or other endocrine disorder? ☐ Yes ☒ No
 - e. anxiety, depression, or any other mental or psychiatric illness? ☐ Yes ☒ No
 - f. an infection caused by the Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other sexually transmitted disease? ☐ Yes ☒ No
 - g. asthma, emphysema, cystic fibrosis, sleep apnea, sarcoidosis, tuberculosis or any other disorder of the lungs or respiratory system? ☒ Yes ☐ No
 - h. a seizure, epilepsy, multiple sclerosis, Parkinson's disease, muscular dystrophy, cerebral palsy, paralysis, Alzheimer's disease or any other disorder of the brain or nervous system? ☐ Yes ☒ No
 - i. an ulcer, hepatitis, cirrhosis, pancreatitis, ulcerative colitis, Crohn's disease or any other disorder of the esophagus, liver, stomach or intestines? ☐ Yes ☒ No
 - j. nephritis, polycystic kidney disease or any other disorder of the bladder, kidney, urinary tract or prostate? ☐ Yes ☒ No
 - k. arthritis, gout, back trouble, or any disease or disorder of the joints, muscles or bones? ☐ Yes ☒ No
 - l. lupus, rheumatoid arthritis, chronic fatigue syndrome, fibromyalgia, or any other disease or disorder of the autoimmune system? ☐ Yes ☒ No
2. Has any person for whom you are applying for coverage to be reinstated ever used:
- a. cocaine, crack, marijuana, heroin, Ecstasy, PCP, LSD, methamphetamine, any other hallucinogenic drug or controlled substance? ☐ Yes ☒ No
 - b. amphetamines, barbiturates, sedatives, opiates or methadone, or controlled substance except as prescribed by a physician? ☐ Yes ☒ No
3. Has any person for whom you are applying for coverage to be reinstated had or been advised to have treatment or counseling for alcohol or drug use or been asked to reduce or eliminate their usage? ☐ Yes ☒ No
4. Other than what has already been disclosed, within the past 5 years, has any person for whom you are applying for coverage to be reinstated:
- a. requested or received disability or compensation benefits? ☐ Yes ☒ No
 - b. been a patient in a hospital or other medical facility, other than for normal childbirth? ☐ Yes ☒ No
 - c. had any other disease, disorder or condition? ☐ Yes ☒ No
 - d. been advised to have surgery, medical tests or diagnostic procedures (other than for HIV)? ☒ Yes ☒ No
5. Is any person for whom you are applying for coverage to be reinstated currently receiving medical treatment or taking any other medication or herbal supplement that has not already been disclosed? ☐ Yes ☒ No

(CONTINUED)

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6. Give complete details of any "Yes" answers for questions 1 – 5, including: **Question number, name, diagnosis, date of onset and recovery, medication/treatment prescribed and the name, address and telephone number of all attending physicians and hospitals.**

FOR ADDITIONAL MEDICAL DETAILS, USE A BLANK SHEET OF PAPER.

- To the best of my knowledge and belief, the statements in this application, as well as any forms that the Company designates to be part of the application and that are attached to the policy, are complete, true and correctly recorded.
- The Company will not contest this reinstatement request after the end of two years from the date of reinstatement, subject to the conditions and exceptions stated in the policy.
- I will inform the Company of any changes to any answers on this application, prior to reinstatement of this policy.
- I have received and read the **Instructions** and the **Important Notice About Your Application for Reinstatement**.
- I understand that this application, if approved, will automatically restore all supplementary benefits and policy riders, unless I specify otherwise.

15



FRAUD WARNING

Any person who knowingly and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company may have committed fraud, or may have violated state law.

Signed at (City, State) _____

SIGN & DATE HERE Primary insured (if age 18 or over) X _____ Date ____/____/____

SIGN & DATE HERE Policyowner (if other than the insured) X _____ Date ____/____/____

SIGN & DATE HERE Joint owner (if applicable) X _____ Date ____/____/____

SIGN & DATE HERE Insured spouse (if coverage on this person is to be reinstated) X ANGELICA POLANCO Date 01/15/2022SIGN & DATE HERE Applicant (if Applicant's Waiver of Premium Benefit is to be reinstated) X Brendo Polanco Date 01/15/2022

- For **corporations**, an authorized officer must sign. Be sure to include the title of the officer and the company name.
 - If **president** – no additional requirements
 - If **vice president** – for policies over \$1,000,000, provide a Corporate Secretary's statement reflecting the vice president's authority to sign
 - If **any other officer** – provide a corporate resolution
- For **limited liability companies**, the individual(s) authorized to act, along with title and company name. Also provide the document (e.g., operating agreement or articles of organization) that defines who is authorized to act for the company.
- For **partnerships** with at least two general partners, two authorized general partners must sign with the title "general partner" after each name (if only one, use "sole general partner") and include the name of the partnership.
- For **sole proprietorships**, submit the signature of the owner, followed by "doing business as (company name), a sole proprietorship."
- For **trusts**, each trustee must sign unless the trust itself or state law provides otherwise. Trustee must include trustee designation (for example, "John Doe, Trustee under Trust Agreement dated 1/1/1998").
- A **holder of power of attorney** for the policyowner (if other than the insured) must provide a copy of the power of attorney and include, following his or her signature, the words "Attorney-in-fact for (owner's name)."
- For a policy containing a **limitation of rights**, the person or entity in whose favor the rights have been limited must also sign.

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EXHIBIT G

CUSTOMER SERVICE OFFICE
P.O. Box 7390
Philadelphia, PA 19176-7390
www.prudential.com

Bernardo Polanco
Po Box 2667
Farmington, NM 87499-2667

Insured: Bernardo Polanco
Policy Number: L9102961

January 25, 2022

Dear Bernardo Polanco:

I am writing to confirm that we received your application and payment to reinstate the policy listed above.

We will review your application for reinstatement and contact you if we need any additional information. **This policy will remain lapsed during the review process.**

If a medical examination or medical records are required as part of the reinstatement evaluation process, a company working on behalf of Prudential will:

- Contact you to schedule the exam. Please review the enclosed brochure which provides more information about the medical examination process.
- Contact your physician(s) directly to obtain the necessary records.

We will notify you of our decision in writing once we complete our evaluation.

If you have any questions or would like more information, please call our customer service office at (800) 782-5356 and refer to reference number ANBMZVGC. We are available Monday through Friday between 8:00 a.m. and 7:00 p.m. Eastern time. If you are using a telecommunications device for the hearing impaired, please call (800) 778-8633, Monday through Friday between 8:00 a.m. and 6:00 p.m. Eastern time. One of our customer service representatives will be glad to help you.

Thank you for choosing us for your insurance and financial needs.

Sincerely,

Alexis Shaw

Alexis Shaw
Associate Manager

EXHIBIT H



Bernardo Polanco
Po Box 2667
Farmington, NM 87499-2667

Insured: Bernardo Polanco
Policy Number: L9102961

February 18, 2022

Dear Bernardo Polanco:

I am writing to confirm that we have processed a request by William A. Fortner to withdraw the reinstatement of the policy listed above.

Please note that you have no insurance coverage under this policy except to the extent of the non-forfeiture provision, if any, specified in your contract.

We will mail a check in the amount of \$4,625.00 under separate cover. This check represents a refund of the payment(s) submitted.

If you have any questions or would like more information, please call our customer service office at (800) 782-5356 and refer to reference number ANBMZVGC. We are available Monday through Friday between 8:00 a.m. and 7:00 p.m. Eastern time. If you are using a telecommunications device if the hearing impaired, please call (800) 778-8633, Monday through Friday between 8:00 a.m. and 6:00 p.m. Eastern time. One of our customer service representatives will be glad to help you.

Thank you for choosing us for your insurance and financial needs.

Sincerely,

Alexis Shaw

Alexis Shaw
Associate Manager

EXHIBIT I

LUG MEMO: CHANGE AND REINSTATEMENT UNDERWRITING**Initial Release Date:** 06/03/2019**History:** Replaces Life Memo 2009-0-134 - Change and Reinstatement Underwriting**GENERAL INFORMATION**

Post issue change requests not guaranteed by the contract generally require evidence of insurability. Underwriting requirements are generally based on the original face amount or increase in risk (i.e., adding a layer to an existing UL or VUL policy) and the attained age of the insured, and are essentially the same as those for New Business. Requests for policy changes may be received during the New Business Change Period (NBCP).

Note: LifePro products do not have a New Business Change Period.

RATING REDUCTIONS**Smoker to NonSmoker****Preferred Category Rating Reductions / Select Underwriting**

REINSTATEMENTS

Reinstatement is the process by which a life insurance company puts back in force a life insurance policy that has either 1) been lapsed because of non-payment of renewal premiums, or 2) has been continued under the extended term or reduced paid up insurance non-forfeiture option.

MyLegacy policies cannot not be reinstated due to the nature of the contract (single pay) **except** if the contract was issued in Pennsylvania.

MyLegacy contract(s) issued in Pennsylvania: Although MyLegacy is a single premium payment policy, the policy can have a loan that may exceed the cash value therefore the state of Pennsylvania requires the policy to contain a reinstatement provision. Follow guidelines for MyTerm reinstatement.

Informal Reinstatement

A reinstatement is considered to be an informal reinstatement, also referred to as a 'reversal of lapse', if it is determined that the policy lapsed through no fault of the policyowner. Permissibility and reinstatement period is subject to various internal guidelines and state regulations. Underwriting is not required on an informal reinstatement.

'No Form' Reinstatement

A "No Form" reinstatement process allows the policy to be reinstated without any forms or underwriting. It is available for cases meeting the following criteria:

- Amount of insurance (sum of all policies being reinstated, including riders) is less than \$250,000 AND policy(ies) lapsed less than one year OR
- MyTerm if the policy has been lapsed less than 59 days.

Long Form Reinstatement

A Long Form reinstatement uses a more in depth application which mirrors the new business application and is required when a request is made to reinstate the policy that is in default or lapsed either:

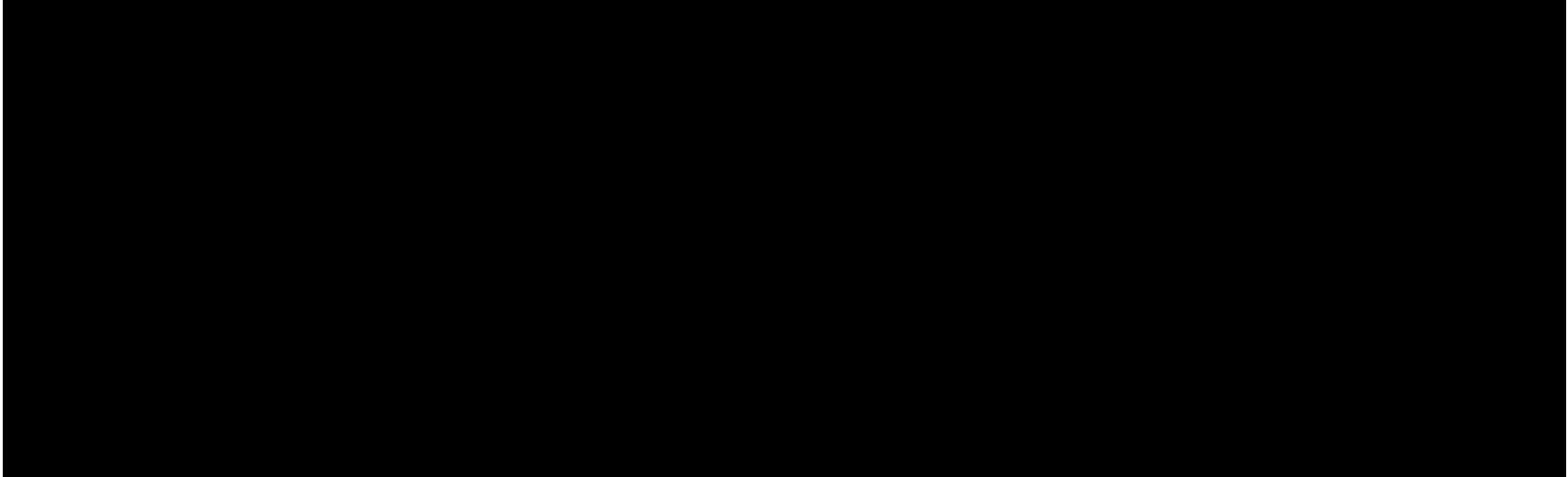
- On or after the 1st policy anniversary of the policy's paid to date OR
- On or after day 63 from the paid to date/date of default for face amounts \$250,000 or more (includes riders on the Insured and Spouse only; benefits such as ADB are excluded) OR
- MyTerm if the policy has been lapsed 59 days or more

In order to reinstate, the policyowner is required to provide all the required premiums along with the application requirements outlined in 'Underwriting Requirements' section below.

UNDERWRITING REQUIREMENTS

Providing satisfactory evidence of insurability is a condition for reinstating a contract.

Standard Underwriting Requirements



Age/Amount Specific Underwriting Requirements

Lapse Period	Face Amount	Age	Requirement(s)
[Redacted Content]			

UNDERWRITING PRESCRIPTION DATABASE CHECKS (RX CHECKS)



	Impairment Table - Underwriting Requirements

FINAL ACTION

--

If original contract issued...	Then ALLOW reinstatement if...

Special Class Ratings

If a rating of more than one class is required, the reinstatement should be denied utilizing the reinstatement rejection wording insert. Temporary and permanent flat extras should also be considered. Status of all PHI records must be obtained to make sure retention or auto-issue limits are not exceeded.

EXHIBIT J



Underwriter Workbench For Policy L9102961

[Home](#) [FAQs](#) [Logoff](#)[Application Summary](#) [Underwriter Workbench](#) [1035 Workbench](#) [Task Box](#) [Requirement Summary](#) [Case Notes](#) [Unplaced Change](#) [Related Applications](#) [Interaction History](#) [Reinsurers](#) [Letters](#)

Browse

Welcome

Application

Task Box

Transaction

Services

Glossary

Underwriter Workbench Information for application **3498425**.

- [Resubmit current application to the underwriting process.](#)
- [New Requirement](#)
- [Create a new task box item for this case.](#)
- [Launch PIWD Assemble Print Package](#)

[Show All](#) | [Hide All](#)

Application Information for BERNARDO POLANCO (Primary)

[Update](#)

Case Type:	RTP - Agency Paper Application
Plan:	Post Issue Product
Benefits and Riders:	
Base Amount of Coverage:	\$1,000,000.00
Net Amount at Risk:	\$1,000,000.00
Total In Force:	\$0.00
Rep Quoted:	
Prepaid (Y/N):	No
Related/Alternate/Additional Policies:	
Amount Replacing:	\$0.00
File Building IGO Status:	

SSN:	N/A
DOB:	
Age:	55
Save Age:	
Gender:	Male

Owner:	BERNARDO POLANCO
Premium Payor:	
Beneficiary:	
Purpose:	

Occupation:	
Earned:	\$0.00
Unearned:	\$0.00
Household:	\$0.00
Net Worth:	\$0.00

Delivery State:	NM
Resident State:	NM

Office Code:	KABX
Producer Name:	WILLIAM A FORTNER
PLC Indicator:	
Life Founders Producer Designation:	

[Update](#)

MIB Results for BERNARDO POLANCO (Primary)



Other BP's



BP Debits:

Average:

Lab Tests

	Date	LDL	HDL	Ratio	Tot Chol	A1C	PSA
IRP Test							
Other Tests							
Average:							

Multiple Requirement Update for BERNARDO POLANCO (Primary)



Name	Status	Level	Satisfy Requirement	Release To Producer
Attending Physician Statement	Satisfied	Insured		<input type="checkbox"/>
Data Verification Report	Satisfied	Insured		
Insurance Risk Profile	Ordered	Insured	<input type="checkbox"/>	<input type="checkbox"/>
MIB	Satisfied	Insured		
Medical Rx Check	Satisfied	Insured		
Motor Vehicle Report	Satisfied	Insured		
Paramedical Exam	Ordered	Insured	<input type="checkbox"/>	<input type="checkbox"/>
Miscellaneous Underwriting Requirements	Satisfied	Policy		

Update

Underwriter Evaluation for BERNARDO POLANCO (Primary)



Create Date	Created By	Details
01/27/2022 10:32:21 AM	Jeanne Merryman	<p>rein</p> <p>55/1mm</p> <p>Orig app issued 2014 NS Class D due to OSA (mod-severe non-compliant +100) vs driving record per notes in X8121813 ; noted for warrant for arrest due to failure appear for speed tix in AZ; mvr had several viol ; business insur but wife bene; several diff needs in one policy</p> <p>Mib</p> <p>L9105866 applied for same time X8 info used for NB</p> <p>Decs:</p> <p>Lov 12-21 check up 5.6.190 M died ovar ca Osa uses cpap Gerd Anx on one med</p> <p>Will not request business supp noting spouse is bene; oil field supervisor, looked at website, services oil wells; mrx no match; full work up</p> <p>Exam irp aps dvr mvr (noting sig viol in the past)</p>
01/27/2022 10:56:21 AM	Jeanne Merryman	<p>Mvr failure to appear; may be related to the one noted in orig file</p> <p>9/20 Oper veh w/o reg 8/19 sp 21-30 over 7/16 speed</p> <p>No concerns; dvr will address failure to appear</p>
02/22/2022 01:21:08 PM	Jeanne Merryman	<p>task from rein</p> <p>: Policy Number L9102961 FMA called and advised that the insured passed away already. Please stop any pending activity for reinstatement . Thank you</p>

Will review aps and then send to UPP

Aps reviewed

1/22
Tele visit
Covid pos; no symptoms, he thinks false pos
Anx has not started meds yet
NASH
Gastritis improved with meds, no bleeding

12/21
HAs
Diarrhea
CP
Dizzy
Htn
OSA
Abd pain; has not taken gerd meds in months; labs ordered
Anx
Cough abx from Mexico

12/21
Testicle pain with bump; was told it's a cyst from MN clinic

CBC/LABS 12/21
HGB 17.7 elv
HCT 52.2 elv
MCV 100 elv
Lfts over 2x elv ; would be ratable

7/21
Tele visit
Started using cpap but cannot tolerate it
Lost 12 lbs, stopped drinking etoh; tired; anxious
Egc with reddened mucosa, per pt bx neg
Steatosis of liver;
Anx
Insomnia

7/21
e.r. for abd pain
notes previous etoh 3-12 beers per day ; dui age 17; quit for 2 yrs in 2013 ; ct to be done
ecg rbbb abd left post fas block
gain of 20 lbs in past week ; abd distention; recently dx fatty liver;
ct borderline hepatomegaly with steatosis final impression notes severe hepatic steatosis
lfts elv over 2x

6/21
Sleep study
AHI 88.9 o2 74%
Split night

6/21
Fol up
Edema went away
Still with ccp
Elv lfts could be due to fatty liver od heart failure
Extreme fatigue; he had significant polycythemia and dr surmised he has not been using
sleep apnea mask; wants another sleep study done and a mask ordered

6/21 nuclear stress test;
Echo mild lvh; 1.1
Calc socre not found, but was done
notes SMOKER

6/21 swollen feet
Angina

4/21
Covid with O2 at 86-90

3/21
Gout

3/21
Follow up on CHF status dias heart failure; echo
Lump in breast u/s

Steatosisliver

Edema

Lfts elv

5/19

Edema

Alcoholism possible alcoholic cardiomyopathy

1/19

Etoh dep naltrexone

2018 smoker

Etoh, fatty liver, lfts, severe polycythemia and severe osa not using cpap

would be a denial but send this to **UPP**

Add Underwriter Evaluation

Rich text editor toolbar with buttons for Bold (B), Italic (I), Underline (U), Bulleted List, Numbered List, Decrease Indent, Increase Indent, Font size, Link, Unlink, Undo, Redo, and a color picker. The editor area is currently empty.

Create

Clear

Images for UW Workbench for BERNARDO POLANCO (Primary)

Doc Number	Doc Type	Create Date	Doc Source
78892691	APS	1/28/2022	Electronic
79841738	FILE-COPIES	5/4/2022	Bronze
78874339	MIB-AUTH	1/27/2022	Bronze
79136642	UNDW-REQ-MISC	2/23/2022	Bronze

Risk Factor Detail for BERNARDO POLANCO (Primary)

Impairment Information									Add
Type	Date	Notes/Description	Debit	Credit	Flat Extra	Temp Extra	Years	Last Update	
SGOT/AST	2/23/2022	SGOT/AST	0.0	0.0	0.00	0.00	0.0	Jeanne Merryman	Update Delete
Liver Disorder	2/23/2022	Liver Disorder	0.0	0.0	0.00	0.00	0.0	Jeanne Merryman	Update Delete
Alcoholism	2/23/2022	Alcoholism	0.0	0.0	0.00	0.00	0.0	Jeanne Merryman	Update Delete
Sleep Apnea	2/23/2022	Sleep Apnea	0.0	0.0	0.00	0.00	0.0	Jeanne Merryman	Update Delete
Hypertension	2/23/2022	Hypertension	0.0	0.0	0.00	0.00	0.0	Jeanne Merryman	Update Delete
Polycythemia Vera	2/23/2022	Polycythemia Vera	0.0	0.0	0.00	0.00	0.0	Jeanne Merryman	Update Delete

Anxiety	2/23/2022	Anxiety	0.0	0.0	0.00	0.00	0.0	Jeanne Merryman	Update Delete
Sub-Total			0.0	0.0	0.00	0.00	0.0		
Total:			0.0	0.0	0.00	0.00	0.0		
MIB Coding Information									
Type	MIB Impairment Code		Modifying letters		Site Code		ECG Codes		
SGOT/AST	924		JZN						
Liver Disorder	510		GZN						
Alcoholism	275		MZN						
Sleep Apnea	416		GZN						
Hypertension	346		JZD						
Polycythemia Vera	351		KZN						
Anxiety	294		TZN						

Preferred Exception for BERNARDO POLANCO (Primary)

Plan:	Post Issue Product																
Benefits and Riders:																	
Base Amount of Coverage:	\$1,000,000.00																
Net Amount at Risk:	\$1,000,000.00																
Total In Force:	\$0.00																
Rep Quoted:																	
<input type="checkbox"/> Build	<input type="text"/> ft. <input type="text"/> in. <input type="text"/> lbs. <input type="text"/> Not Selected																
<input type="checkbox"/> Blood Pressure	<input type="text"/> Not Selected																
<input type="checkbox"/> Blood Pressure Medication	<input type="text"/> Not Selected																
<input type="checkbox"/> Cholesterol Ratio	<input type="text"/> Not Selected																
<input type="checkbox"/> Family History	<table><tr><td><input type="text"/> Not Selected</td><td><input type="text"/></td><td><input type="text"/> Not Selected</td><td><input type="text"/></td></tr><tr><td><input type="text"/> Not Selected</td><td><input type="text"/></td><td><input type="text"/> Not Selected</td><td><input type="text"/> Not Selected</td></tr><tr><td><input type="text"/> Not Selected</td><td><input type="text"/></td><td><input type="text"/> Not Selected</td><td><input type="text"/></td></tr><tr><td><input type="text"/> Not Selected</td><td><input type="text"/></td><td><input type="text"/> Not Selected</td><td><input type="text"/></td></tr></table>	<input type="text"/> Not Selected	<input type="text"/>	<input type="text"/> Not Selected	<input type="text"/>	<input type="text"/> Not Selected	<input type="text"/>	<input type="text"/> Not Selected	<input type="text"/> Not Selected	<input type="text"/> Not Selected	<input type="text"/>	<input type="text"/> Not Selected	<input type="text"/>	<input type="text"/> Not Selected	<input type="text"/>	<input type="text"/> Not Selected	<input type="text"/>
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<input type="checkbox"/> Tobacco	<input type="text"/> Not Selected																
<input type="checkbox"/> Occupation	<input type="text"/> Not Selected																
<input type="checkbox"/> Aviation	<input type="text"/> Not Selected																
<input type="checkbox"/> Avocation	<input type="text"/> Not Selected																
<input type="checkbox"/> Personal History	<input type="text"/> Not Selected <input type="text"/> Not Selected																
<input type="checkbox"/> Driving	<input type="text"/> Not Selected																
<input type="checkbox"/> Drug/ETOH	<input type="text"/> Not Selected																

Rating Based on Criteria :	<input type="text"/> Not Selected	Recommended Rating :	<input type="text"/> Not Selected
Exception Request Source :	<input type="text"/> Not Selected	Officer's decision :	<input type="text"/> Not Selected

Preferred Exception Evaluation

Add Preferred Exception Evaluation

B I U	Font size	
<div></div>		

Create

Clear

Underwriting Guidelines for BERNARDO POLANCO (Primary)

No Underwriting Guidelines Available

Modify Decision for BERNARDO POLANCO (Primary)

System Overrides

Force Serial Underwriting:

Restrict Auto-Approval:

Internal RRP:

Rating Details for BERNARDO POLANCO (Primary)

Decision : FIU Rejected *Rejection Type:

Base Coverage

Post Issue Product \$1,000,000

Riders/Benefits

Comment about Decision for Producer

Maximum comment length of 4000 characters.

Please include medical requirements if necessary.

Fields denoted with an * are required.

- [Resubmit current application to the underwriting process.](#)

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EXHIBIT K

**Prudential**

Pruco Life Insurance Company,
a Prudential Financial company
PO Box 41594, Philadelphia, PA 19176
www.prudential.com

Reason for Check: DEATH CLAIM
Check Number: L 1080899508
Check Amount: \$515,750.82
Date of Check: March 17, 2022
Policy Type: TERM
Policy Number: L9 105 866
Insured Name: BERNARDO POLANCO

L 1080899508
ANGELICA POLANCO
1560 SAGUARO TRL
FARMINGTON

NM 87402

Your Check Statement

Page 1 of 1

This check for \$515,750.82 represents the proceeds from the claim on policy L9105866.

Source of Funds	Face Amount of Insurance	\$1,000,000.00
	Premiums Returned	\$295.41
	Interest From Date of Death	\$1,960.58
	Deductions	
	Payments Made or Pending	\$486,505.17
Amount of Check		\$515,750.82

- If the deceased was named as a beneficiary on any other insurance policies, we suggest that beneficiary be named as soon as possible.
- Social Security benefits may be available. Call your local federal Social Security office for

We hope we have been of help to you during this difficult time. If you have any questions or would like more information, please call our Claims Area toll free at 800-496-1035. We are available Monday through Friday between 8:00 a.m. and 8:00 p.m. Eastern Time. One of our customer service representatives will be glad to help you.

R90802Q PTD 02192022

Detach before cashing or depositing check. Please retain this check statement for future reference.

VOID
L 108089950

**Prudential**

Pruco Life Insurance Company,
a Prudential Financial company
PO Box 41594, Philadelphia, PA 19176
www.prudential.com

Wells Fargo Bank, NA

64-975
612

POLICY NUMBER L9 105 866

516

Pay: ***FIVE HUNDRED FIFTEEN THOUSAND SEVEN HUNDRED FIFTY*
AND 82/100 DOLLARS*****

March 17, 2022

*****515,750.82

Void after 180 days

Dollars Cents.

To the Order of: ANGELICA-POLANCO*****
VOID*****

VOID

VOID
Nandine Mendez
Treasurer, Prudential

And Axel
Controller, Prudential

Controller, Prudential

Security Features Included (Details on Back)

MP

1080899508

VOID

061209756 2079900413603

04/04/2207.4169.000.498

00000072 00144 0002-0002 DIXC05D5031722022805 001 00000072

04/24/20207.4169.000.499

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SC:

191767339

1755-99564-23-67

RETURN TO SENDER
UNABLE TO FORWARD

NIXIE

271

FE 2319

0003/23/22



FIRST-CLASS MAIL
PRESORTED
U.S. POSTAGE PAID
KIS Output Solutions

EXHIBIT L


Prudential

Customer Service Office
P.O. Box 13902
Philadelphia, PA 19176
www.prudential.com

Angelica Polanco
Po Box 2667
Farmington, NM 87499

Insured: Bernardo Polanco
Policy Number: L9105866

April 5, 2022

Dear Angelica Polanco:

Thank you for providing us with the necessary documentation to review your claim. We have approved the claim for benefits on the policy listed above in the amount of \$515,750.82.

As requested, a check for \$515,750.82 has been mailed in a separate envelope.

Amounts included in the benefit

Face Amount of Insurance	\$1,000,295.41
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Amounts deducted from the benefit

Payments Made to Others	\$486,505.17
-------------------------	--------------

Benefit due	\$513,790.24
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Adjustments

Interest	\$1,960.58
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Total Benefit	\$515,750.82
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We thought it might be helpful to explain the following payments or deductions shown in the above death benefit calculation:

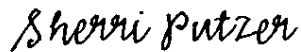
Payments Made or Pending: Includes death claim benefits payable to other parties, and/or benefits not yet paid.

Please note that this interest represents a taxable amount and may be reported to you and to the IRS on Form 1099-INT, if applicable. We have presented this information based on our understanding of tax law. You may wish to consult with your tax advisor if you have any tax questions. Because each situation is unique, neither we nor our representatives can provide tax advice.

This statement concerns benefits payable under policy number L9105866 only. If claims were submitted for the insured under any other Prudential policies, they will be processed separately. Social Security benefits may also be available. You might want to contact the appropriate government office in your area for more information. In addition, if Bernardo Polanco was named as a beneficiary on any

Bernardo Polanco was a valued Prudential customer, and we are pleased to carry out our obligation to you. We appreciate your assistance during our review of the claim. If you have any questions or would like more information, please call our customer service office at (800) 496-1035 and refer to reference number ANF43FN2. We are available Monday through Friday between 8:00 a.m. and 8:00 p.m. Eastern time. If you are using a telecommunications device for the hearing impaired, please call (800) 778-8633, Monday through Friday between 8:00 a.m. and 6:00 p.m. Eastern time. One of our customer service representatives will be glad to help you.

Sincerely,

A handwritten signature in black ink that reads "Sherri Putzer". The script is cursive and fluid.

Sherri Putzer
Customer Service Representative

EXHIBIT M

**Prudential****APPLICATION FOR LIFE INSURANCE****PART 1**

- ☒ Pruco Life Insurance Company
☐ The Prudential Insurance Company of America
Both are Prudential Financial companies.
 Corporate Offices, Newark, New Jersey

POLICY NUMBER (IF KNOWN): L9105866**A. PROPOSED INSURED (POLICY OWNER UNLESS SECTION D IS COMPLETED)**

1. Name: BERNARDO POLANCO
 2. Previous name (if changed in the last 5 yrs.): _____
 3. Social Security number: _____ 4. State of birth (Country if not U.S.): MEXICO
 5. Gender: ☐ Female ☒ Male 6. Date of birth: _____ 7. Date policy to Save Age? ☐ Yes ☒ No
 8. Are you a permanent, legal US resident? ☒ Yes ☐ No
If No, provide country of legal residence, type and number of visa, expiration date and length of US residence:

 9. Driver's license issuing state: NM Number: _____ Expiration date: 09/20/2014
If None, why not?: _____
 10. Residence address (No PO boxes): Street 1560 SAGUARO TRL Apt _____
 City FARMINGTON State NM ZIP 87401
 11. e-mail address: _____
 12. Home telephone number: (505) 486-1717 Business telephone number (ext.): _____
 13. Current employer name: ELMRIDGE EXPLORATION DBA TRIPLE P WELL S
 Business address: Street 12225 GREENVILLE AVE Suite 950
 City DALLAS State TX ZIP 75243
 14. Occupation: VP MANAGER OILFIELD
 Duties: MANAGES THE RIG MOVES ETC
 15. Earned annual income \$ 180,000 Unearned annual income \$ 0 Net worth \$ 10,000,000

B. PLAN OF INSURANCE

1. Amount of insurance applied for: \$ 1,000,000 Complete Financial Supplement with face amounts of \$5,000,000 or more up to age 70, \$2,500,000 or more ages 71-80, \$1,000,000 or more ages 81 and up.
 2. Product applied for: ☒ Term Essential®: ☒ 10 ☐ 15 ☐ 20 ☐ 30 ☐ PruLife® Universal Life Plus (UL Plus)
☐ Term Elite®: ☐ 10 ☐ 15 ☐ 20 ☐ PruLife® Universal Life Protector (UL Protector)
☐ ROP Term: ☐ 15 ☐ 20 ☐ 30 ☐ VUL Protector™ (VULP) Complete the Variable Supplement.
☐ PruLife® Custom Premier II (VUL II) ☐ Other: _____
 Complete the Variable Supplement.
 3. For UL Plus, UL Protector, VULP and VUL II: Death Benefit type:
☐ Type A (Level) ☐ Type B (Variable) ☐ Type C (Return of Premium) – Not available for UL or VUL Protector. – Interest rate: _____ %
 4. For UL Plus, VULP and VUL II: Definition of life insurance:
☐ Cash Value Accumulation Test (CVAT) ☐ Guideline Premium Test (GPT)
 5. Requested Optional Benefits (Not all benefits are available for all products.):
☐ Waiver of Premium/Enhanced Disability Benefit ☐ Overloan Protection Rider
☐ Acceleration of Death Benefit (Living Needs Benefit) ☐ Child Rider Complete Child Rider Supplement.
☐ Accidental Death Benefit: Amount \$ _____ ☐ Automatic Premium Loan
☐ Other Riders/Benefits (indicate amount where applicable): _____ ☐ Enhanced Cash Value Rider

C. PREMIUM

1. Send notices (check one): ☒ Policyowner ☒ Other recipient: Elm Ridge Exploration Co, LLC
 Send notices (check one): ☒ Policyowner's residence ☐ Other address
 Street 12225 Greenville Ave Ste 950 Apt _____
 City Dallas State TX ZIP 75243
 2. Premium payment mode: ☐ Annual ☐ Semiannual ☐ Quarterly ☒ Monthly – Electronic Funds Transfer
 3. For non-term plans, billed premium: \$ _____



AGREEMENTS

By signing this form, I have carefully reviewed the application including all supplements attached to the policy, and I agree to the following:

- To the best of my knowledge and belief, the statements in this application are complete, true and correctly recorded.
- Except for failure to pay premium, the validity of this policy will not be contested after it has been in force during the insured's lifetime for two years from the date it takes effect.
- If I have requested the Acceleration of Death Benefits (Living Needs Benefit), I have read the disclosures in the Living Needs Benefit brochure.
- My original signature has been affixed to this application, the original will be retained by the Company named at the beginning of this application ("Company"). The copies attached to the policy issued to me are identical in form and substance.
- Any policy issued on this application shall not take effect until after all of the following conditions are met:
 - A payment equal to the full first required premium is received by the Company within the lifetime of the proposed insured. A payment will only be considered to be received if one of the following valid items is received by the Company: (i) a check in the amount of the full first required premium; (ii) a completed and signed payment form for the first full premium; or (iii) any other form of payment acceptable to the Company.
 - The form of payment submitted is honored. If payment is made by credit/debit card, wire transfer or automatic bank draft, no premium is considered to be honored until the Company actually receives the funds unless otherwise provided by applicable law.
 - A signed copy of this Application is received by the Company.
 - The Owner has personally received the policy during the lifetime of and while the health of the Proposed Insured is as stated in this application.
- Only an officer of the Company with the rank or title of Vice President may make or alter any contract or agree not to enforce any of the rights of the Company, and then only in writing. **No producer or medical examiner is authorized to accept risks, pass on insurability, make or alter contracts, or waive any of the other rights or requirements of the Company.** Notice to or knowledge imputed to any producer or medical examiner will not be notice of or knowledge to the Company unless it is set out in writing in this application.

FRAUD WARNING

(Not applicable in AZ.) Any person who knowingly:

- **AR, HI, LA, NM, TN, VA and WA:** and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company may be subject to fines, denial of insurance benefits, or confinement in prison.
- **AL:** presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.
- **CO:** and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company may have committed fraud, or may have violated state law. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
- **DC and RI:** presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- **OH:** and with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
- **PA:** and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
- **All other states:** and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company may have committed fraud, or may have violated state law.

SIGNATURES

Check applicable boxes:

IRS Certification: Under penalties of perjury, the policyowner certifies that:

- ☒ The number shown on the application is my correct Social Security/Tax ID number.
- ☒ I am not subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code.
- ☒ I am a U.S. person (including a U.S. resident alien). *If not a U.S. person (including U.S. resident alien), submit the applicable Form W-8(BEN, ECI, EXP or IMY). In most cases, Form W-8BEN will be the appropriate form.*

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signed at (STATE) NEW MEXICO

on (DATE)

8.10.14 9.18.14

→ Signature of proposed insured

X

If policyowner is different from the proposed insured:

→ For a personal policyowner(s): Signature(s) of policyowner(s)

X

For an entity policyowner(s) (i.e., trust, business):

Name of entity

→ Signature of officer/trustee(s)

X

Title of officer/trustee(s)

→ Signature of producer

X

EXHIBIT N

**Prudential****APPLICATION FOR LIFE INSURANCE****PART 1**

- ☒ Pruco Life Insurance Company
☐ The Prudential Insurance Company of America
Both are Prudential Financial companies.
 Corporate Offices, Newark, New Jersey

POLICY NUMBER (IF KNOWN): L9102961**A. PROPOSED INSURED (POLICY OWNER UNLESS SECTION D IS COMPLETED)**

1. Name: BERNARDO POLANCO
 2. Previous name (if changed in the last 5 yrs.): _____
 3. Social Security number: _____ 4. State of birth (Country if not U.S.): MEXICO
 5. Gender: ☐ Female ☒ Male 6. Date of birth: _____ 7. Date policy to Save Age? ☐ Yes ☒ No
 8. Are you a permanent, legal US resident? ☒ Yes ☐ No
If No, provide country of legal residence, type and number of visa, expiration date and length of US residence :

 9. Driver's license issuing state: NM Number: _____ Expiration date: _____
If None, why not? : _____
 10. Residence address (No PO boxes): Street 1560 SAGUARO TRL Apt _____
 City FARMINGTON State NM ZIP 87401
 11. e-mail address: _____
 12. Home telephone number: (505) 486-1717 Business telephone number (ext.): _____
 13. Current employer name: ELMRIDGE EXPLORATION DBA TRIPLE P WELL S
 Business address: Street 12225 GREENVILLE AVE Suite 950
 City DALLAS State TX ZIP 75243
 14. Occupation: VP MANAGER OILFIELD
 Duties: MANAGER
 15. Earned annual income \$ 180,000 Unearned annual income \$ 0 Net worth \$ 10,000,000

B. PLAN OF INSURANCE

1. Amount of insurance applied for: \$ 1,000,000 Complete *Financial Supplement* with face amounts of \$5,000,000 or more up to age 70, \$2,500,000 or more ages 71-80, \$1,000,000 or more ages 81 and up.
 2. Product applied for: ☒ Term Essential[®]: ☒ 10 ☐ 15 ☐ 20 ☐ 30 ☐ PruLife[®] Universal Life Plus (UL Plus)
☐ Term Elite[®]: ☐ 10 ☐ 15 ☐ 20 ☐ PruLife[®] Universal Life Protector (UL Protector)
☐ ROP Term: ☐ 15 ☐ 20 ☐ 30 ☐ VUL ProtectorSM (VULP) Complete the *Variable Supplement*.
☐ PruLife[®] Custom Premier II (VUL II) ☐ Other: _____
 Complete the *Variable Supplement*.
 3. For **UL Plus**, **UL Protector**, **VULP** and **VUL II**: Death Benefit type:
☐ Type A (Level) ☐ Type B (Variable) ☐ Type C (Return of Premium) **Not available for UL or VUL Protector.** Interest rate: _____%
 4. For **UL Plus**, **VULP** and **VUL II**: Definition of life insurance:
☐ Cash Value Accumulation Test (CVAT) ☐ Guideline Premium Test (GPT)
 5. Requested Optional Benefits (Not all benefits are available for all products.):
☐ Waiver of Premium/Enhanced Disability Benefit ☐ Overloan Protection Rider
☐ Acceleration of Death Benefit (Living Needs Benefit) ☐ Child Rider Complete *Child Rider Supplement*.
☐ Accidental Death Benefit: Amount \$ _____ ☐ Automatic Premium Loan
☐ Other Riders/Benefits (indicate amount where applicable): ☐ Enhanced Cash Value Rider

C. PREMIUM

1. Send notices (check one): ☒ Policyowner ☐ Other recipient:
 Send notices (check one): ☒ Policyowner's residence ☐ Other address:
 Street _____ Apt _____
 City _____ State _____ ZIP _____
 2. Premium payment mode: ☐ Annual ☐ Semiannual ☐ Quarterly ☒ Monthly Electronic Funds Transfer
 3. For non-term plans, billed premium: \$ _____



AGREEMENTS

By signing this form, I have carefully reviewed the application including all supplements attached to the policy, and I agree to the following:

- To the best of my knowledge and belief, the statements in this application are complete, true and correctly recorded.
- Except for failure to pay premium, the validity of this policy will not be contested after it has been in force during the insured's lifetime for two years from the date it takes effect.
- If I have requested the Acceleration of Death Benefits (Living Needs Benefit), I have read the disclosures in the Living Needs Benefit brochure.
- My original signature has been affixed to this application, the original will be retained by the Company named at the beginning of this application ("Company"). The copies attached to the policy issued to me are identical in form and substance.
- Any policy issued on this application shall not take effect until after all of the following conditions are met:
 - A payment equal to the full first required premium is received by the Company within the lifetime of the proposed insured. A payment will only be considered to be received if one of the following valid items is received by the Company: (i) a check in the amount of the full first required premium; (ii) a completed and signed payment form for the first full premium; or (iii) any other form of payment acceptable to the Company.
 - The form of payment submitted is honored. If payment is made by credit/debit card, wire transfer or automatic bank draft, no premium is considered to be honored until the Company actually receives the funds unless otherwise provided by applicable law.
 - A signed copy of this Application is received by the Company.
 - The Owner has personally received the policy during the lifetime of and while the health of the Proposed Insured is as stated in this application.
- Only an officer of the Company with the rank or title of Vice President may make or alter any contract or agree not to enforce any of the rights of the Company, and then only in writing. **No producer or medical examiner is authorized to accept risks, pass on insurability, make or alter contracts, or waive any of the other rights or requirements of the Company.** Notice to or knowledge imputed to any producer or medical examiner will not be notice of or knowledge to the Company unless it is set out in writing in this application.

FRAUD WARNING

(Not applicable in AZ.) Any person who knowingly:

- **AR, HI, LA, NM, TN, VA and WA:** and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company may be subject to fines, denial of insurance benefits, or confinement in prison.
- **AL:** presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.
- **CO:** and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company may have committed fraud, or may have violated state law. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
- **DC and RI:** presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- **OH:** and with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
- **PA:** and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
- **All other states:** and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company may have committed fraud, or may have violated state law.

SIGNATURES

Check applicable boxes:

IRS Certification: Under penalties of perjury, the policyowner certifies that:

- ☒ The number shown on the application is my correct Social Security/Tax ID number.
- ☒ I am not subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code.
- ☒ I am a U.S. person (including a U.S. resident alien). If not a U.S. person (including U.S. resident alien), submit the applicable Form W-8(BEN, ECI, EXP or IMY). In most cases, Form W-8BEN will be the appropriate form.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signed at (STATE) NEW MEXICO

on (DATE)

9.10.14

→ Signature of proposed insured

X

Brenda Palmer

If policyowner is different from the proposed insured:

→ For a personal policyowner(s): Signature(s) of policyowner(s)

X

For an entity policyowner(s) (i.e., trust, business):

Name of entity

→ Signature of officer/trustee(s)

X

Title of officer/trustee(s)

→ Signature of producer

X

Bill Foster